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DIVISION OF HEALTH POLICY AND FINANCE

Kansas Division of Health Policy and Finance

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Omnibus Budget Review Information

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1. The Budget Committee recognizes the importance of supporting health insurance for small business employees, but feels more information about the Business Health Policy Committee pilot project is necessary before it can approve funding.

Business Health Partnership Rationale

The majority of the uninsured live in households where at least one person is employed. The working uninsured are overwhelmingly employed by small businesses of 2 to 50 employees at low-wage jobs with compensation under 200% FPL. Research indicates that in order to assist people in getting employer based insurance in these markets it is necessary to provide an incentive to both the employee to take the insurance that is offered, and also to the employer to offer the insurance. This program will take advantage of both an existing tax credit that passed last year that was designed to encourage small businesses to offer health insurance, and a sliding scale subsidy to encourage employees to take-up the insurance that is offered. The program is limited to small businesses employing 2 to 25 where the bulk of the uninsured currently exist. It will serve those businesses and their employees if they are under 200% FPL and have not had insurance offerings in the last two years.

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Sedgwick County was picked as the pilot site in order to assess the impact and viability of this product. The program that is being offered was approved unanimously by all Committee members, four of whom are Legislators.

The plan design and offering was developed with the cooperation of Mercer Consulting.
Empoyees will enroll and then undergo a process to determine if they are eligible for the subsidy. The Department of Revenue will help to assess whether they are eligible for the tax credit, and the premium will likely be paid by the Authority. It is also likely that the premium will be collected by the Authority.

The plan is designed with a $500 deductible and co-payments that encourage appropriate utilization. In addition, the plan is designed to provide first dollar coverage for preventative care.

The bidding to offer the plan closes on April 28th. There are currently two bidders likely to participate. The date of implementation of the new plan will be part of negotiations with the bidders or winning bidder. It is likely, the winner will be pricing a plan that they already offer, rather than creating a new plan.

2. The Budget Committee notes with concern that this program expands eligibility for both Medicaid and SCHIP that may not be sustainable if another economic downturn occurs. In addition, federal matching dollars for SCHIP are limited and Kansas already uses all of its SCHIP, as well as SCHIP dollars unused by other states that are redistributed periodically by the federal government. If the Kansas SCHIP program exceeds the federal funds available, the additional cost must be paid from state dollars. Given the cut-backs that became necessary in Missouri and Tennessee when program expansion became unsustainable, the Budget Committee recommends review of this item during Omnibus when more detailed cost estimates will be available from the agency.

Healthy Kansas First Five:

Why First Five?

Healthy Kansas First Five is part of the Governor's strategy to address the health insurance needs of low income, working families.

- The emphasis on pregnant women, infants, and young children stems from the documented need to provide a healthy start in life through prenatal care and early detection and screening. First Five is a measured approach to expanding health insurance coverage to Kansans that need it most.

- The Governor's First Five proposal is designed to protect children that have traditionally had access to affordable private health insurance coverage. In the past few years, private health insurance coverage has been in decline across the country. Fewer employers are offering insurance, and the rapid rise of health insurance premiums has led an increasing number of families to reject job-based insurance even when they have access to it.

- In the midst of this decline in private coverage, the Medicaid and SCHIP programs have been widely credited with protecting children from the ranks of the uninsured. Nevertheless, the job is not complete.

- We estimate that approximately 15,000 Kansas children five years old and younger are uninsured. Of these, 10,000 live in families with incomes under 200 percent of the federal poverty level (FPL) and would otherwise be eligible for HealthWave. DHPF estimates that the Governor's initiative would provide coverage to approximately one-quarter of uninsured children age 0-5 in the first full year of operation.

The Governor has recommended two initiatives to help provide health insurance coverage for these children: presumptive eligibility and a coverage expansion designed to ensure that every child age zero to five has access to affordable health insurance.

Coverage expansion and buy-in

The Governor recommended $3.5 million from the State General Fund to provide access to affordable health insurance for all Kansas children from birth through age five.

- This initiative would raise the Medicaid eligibility level for pregnant mothers and infants from the current level of 150 percent to 185 percent of the federal Poverty Level (FPL) and increase the SCHIP eligibility level for children one year to five years of age to 235 percent of FPL.

- Families with children above 235 percent of poverty who do not have access to any employer based insurance and who have been without insurance for six months will be allowed to buy into the HealthWave benefit package through a premium based on household income. Above 300% of poverty, families would pay the full actuarial cost to enroll their children in HealthWave.

- DHPF estimates that approximately 2,000 children will participate in this new program in FY 2007.

Impact on private coverage. At higher income levels, families often have access to private insurance. First Five will incorporate two mechanisms to prevent the crowd out of private insurance:

- families would have to provide evidence that the children do not have access to employer based health insurance; and

- to enroll, children must have been uninsured for at least six months prior to becoming eligible for the HealthWave buy in.

Impact on federal SCHIP funding. The First Five initiative would have only a modest impact on federal SCHIP funding in Kansas.

- Based on current policy and spending the state faces a shortfall of about 10 percent of the total SCHIP federal spending in federal fiscal year 2007. DHPF estimates that the First Five coverage expansion would result in only a 2.6 percent increase in SCHIP spending.

- The more important question is whether Congress will continue to fully fund state SCHIP programs as it has to date (FY 2006). Kansas finds itself among a number of politically powerful states – representing

a majority of SCHIP enrollment nationally -- with uncertainty about the sufficiency of federal SCHIP funding in FFY 2007 and beyond.

- In federal fiscal year (FFY) 2004, Kansas joined 35 other states in outspending their federal SCHIP allotment for the year; even in FFY 2004 some states spent double or even triple their allotment. Some of the largest and most influential states are faced with the largest SCHIP funding shortfalls, including New York, New Jersey, and Florida.

- Despite these shortfalls, states have been able to fully fund their programs by using (i) federal funds left over from SCHIP's first years when the program had not yet matured and (ii) supplemental appropriations such as the $283 million included in the Deficit Reduction Act of 2006.

- If Congress follows precedent, they are likely to make additional funds available to states in FY 2007, although there is no way to predict how much will be made available. Beyond FFY 2007 the uncertainty grows: the SCHIP program was only authorized for ten years, through FFY 2007, so there are no SCHIP allotments on the books going forward.

- It is highly unlikely that Congress would fail to fund SCHIP at all given the immediate impact on the 4 million children that the program covers. However, any prediction of the nature of federal funding going beyond FFY 2007 is speculative.

Possible funding shortfalls. Should Kansas face either federal funding shortfalls or the need to pare back state spending, it has two powerful mechanisms to curtail costs associated with the First Five initiative:

- Adjust benefits or family contributions to increase personal responsibility. Co-payments and family premiums in Kansas' existing SCHIP program are very modest in comparison with prevailing levels in the private insurance market and could be raised under current law or with flexibility typically available under a federal waiver. The Governor's First Five initiative includes more significant premiums for children above 235 percent of the poverty level. Should program funding become an issue, the state could increase contributions for the SCHIP population, which would serve as both a source of additional revenue and increase deterrent to enrollment; and/or

- Replace limited federal SCHIP funds with open-ended federal Medicaid funds. Through its matching payments the federal government funds 72 percent of state SCHIP expenditures, compared to a 60 percent share for Medicaid expenditures. The cost to the state for folding (all or a portion of) the SCHIP program back into Medicaid is an increase in the state's contribution from 28 percent of the full cost to 40 percent of the full cost – a difference of just 12 percent of total SCHIP program costs. Converting the entire SCHIP program would cost only a few million dollars – the worst-case scenario should federal SCHIP funding end altogether. More likely, the state might need to take a middle road, using all available SCHIP funding at the higher match rate and filling in with Medicaid funds to ensure that the state does not have to turn away uninsured children.

3. The Budget Committee expresses concern regarding the burden the presumptive eligibility program will put on providers, who will have to implement the screening process after training from the agency, with no additional reimbursement. The Budget Committee asks that the agency report back during Omnibus with the number of other states that are using presumptive eligibility and whether or not providers are being reimbursed.

Presumptive Eligibility:

Number of States/Payment

There are 12 states with provisions that allow for presumptive eligibility determinations for Medicaid and/or SCHIP. Designated entities are not reimbursed for completing a screening tool in other states.

By Federal regulation, certain entities may be selected by States as designated entities to perform presumptive eligibility determinations. Entities so designated voluntarily participate, complete training, and are the only entities authorized by the single state Medicaid agency to complete presumptive eligibility determinations.

By Federal law, designated entities are not allowed to conduct formal eligibility determinations for Medicaid. Rather, they complete a brief screening tool comparing household size, income and age of children to determine presumptively if the child is likely to meet the criteria for Medicaid or SCHIP eligibility. The electronic tool developed by Kansas calculates income and household numbers automatically for the providers to determine presumptive eligibility. Designated entities selected in Kansas are Medicaid providing hospitals and safety net clinics. The Division of Health Policy and Finance staff will provide training sessions approximately 3 hours in length to designated entities at negotiated times and locations. After training, designated entities complete the screening tool which determines uninsured children presumptively eligible. Then, they may seek reimbursement by billing Medicaid for any services the presumptively eligible child receives. Payment for services is provided even if the child is later determined ineligible, or fails to complete the formal application process.

Annual PE Determination

Families may request presumptive eligibility determination for one or all children in the family. Each child may only be determined presumptively eligible once during a twelve month time period. If a family with two children has one child that is screened by the designated entity, that child's sibling may be screened then also, or at a later date, pursuant to the family's wishes.

Provider Perception

This initiative was discussed with the Kansas Hospital Association and the Kansas Association for the Medically Underserved. The proposed project was well received during the discussion. The two Associations responded favorably to using the process as an outreach tool to enroll children who already qualify for Medicaid or SCHIP. Both Associations cited the potential to reduce the burden of unreimbursed care at member facilities for children who are otherwise Medicaid eligible, but remain unenrolled.

4. The Budget Committee recommended a reduction in FY 2006 and FY 2007 funding for Enhanced Care Management pending Omnibus consideration of the item to give it an opportunity to review actual expenditures in FY 2006.

Enhanced Care Management:

Program Background

Enhanced Care Management is a pilot project designed to improve health outcomes and investigate the potential for program savings by addressing Medicaid utilization by chronically ill patients. The project has a 5-year term and is estimated to cost $2 million per year. Participants for this project are identified through the primary care case management program, Health Connect. Data for the participants including claims, demographic information, and diagnostic information is processed through modeling software to provide a risk score reflecting a person's likelihood to have high health care resource needs in the future.

The goals of this project are to improve health outcomes by managing health benefit utilization through education, access to community services, and balanced advocacy.

The organization contracted to administer this project is Central Plains Regional Health Care Foundation. Central Plains is an extension of the not-for-profit Sedgwick County Medical Society. Central Plains has provided services to the uninsured population over the last six years using appropriate utilization management strategies. Central Plains has demonstrated the ability to build and maintain relationships within the professional community and its service population.

Enhanced Care Management was implemented in Sedgwick County and service delivery began March 1, 2006. The implementation in a single county allows for the opportunity to evaluate the project against a reference population to measure its impact over time.

External evaluation of this project has been contracted to Trajectory HealthCare LLC. Project evaluation will be conducted throughout the term of the project to ensure that opportunities to adjust the design are recognized early and implemented quickly.

Budget Recommendations

The Final Report presented to the 2003 Legislature by the President's Task Force on Medicaid Reform was the primary driver behind the creation of the Enhanced Care Management project. The Task Force developed strategies to achieve optimal benefit for the health of chronically ill Kansans, and to reduce the costs of these Kansans' overutilization of high cost services such as Emergency Room Care. Target Care management was the methodology determined most appropriate. The Task Force recommended investment for the purposes of "learning from mistakes" and ultimately expanding the program. The premise was stated that care management is a long-term commitment for which the Legislature must be a "trustworthy partner."

In 2004, SRS reported to the Senate Federal and State Affairs Committee on plans in accordance with recommendations of the Task Force for the pilot care management program. At that time the chronic illnesses of focus were outlined, and Sedgwick County had been identified as a county capable of providing the

specialized services. At no time did the Legislature communicate a response.

The reduction in the FY 2006 approved budget was $1,066,667 SGF and $500,000 SGF in FY 2007. However, this program is federally matchable given that it provides services to Medicaid beneficiaries. Therefore, the reduction in funding is substantially greater than the amount that has been reported.

[All Figures below are in terms of SGF unless marked otherwise]

FY 2006

- The FY 2006 approved budget included $792,806 SGF.
- The approved supplemental budget for FY 2006 reduced the amount by $1,066,667 SGF, leaving a net appropriation of $ -273,861 SGF.
- DHPF's revised projection of actual expenditures for FY 2006 is $443,200 SGF since the project started in April. Money was spent in November for startup costs, and two monthly payments have already been made.
- The FY 2006 shortfall is $717,061 SGF.
- $717,061 SGF needs to be restored, so that it can be federally matched, and we can continue to meet our contractual obligations.

FY 2007

- The FY 2007 Governor's Budget included $800,000 SGF, but that was reduced by $500,000 SGF leaving $300,000 SGF.
- The estimated impact of the FY 2007 budget reduction would be to reduce the number of participants by more than half.

Overview

- The pilot project is designed to serve 500 Kansans each month, a number deemed sufficient to validate the program's impact on health outcomes and costs.
- Given the minimum resource requirements to provide enhanced care management services to each participant, the reduction in funding in FY 2006 and FY 2007 will reduce the number of Kansans served by the program.
- This reduction would limit the value of the pilot project in identifying the impact of this innovate service on health outcomes and costs.

5. A proviso was added by the Committee in FY 2007 requiring the state employees' health benefits plan for prescription drugs to allow beneficiaries to purchase prescriptions from local pharmacies at the same or a lesser price than the mail-order pharmacy used by the state for the maximum number of days allowed by the provider they have selected.

Proviso – Prescription Drug Rates:

The House Social Services Budget Committee has attached a proviso to the Kansas Health Policy Authority (KHPA) budget for Fiscal Year 2007 which requires specific changes in the pharmacy component of the state employees' health benefits plan. We are concerned that this proviso:

- imposes on the longstanding independence of the State Employees' Health Care Commission.
- increases the cost of health benefits for employees and the state.

We discern in the language of the proviso one distinct mandate. Beneficiary prices for mail-order pharmacies be no lower than retail pharmacy prices despite the mail-order cost advantage.

The proviso would dictate specific changes in the design, cost, and financial structure of the state employees' health benefits plan, all of which have historically been determined by the State Employees' Health Care Commission. While the legislature has stipulated from time to time that certain health benefits be included or excluded from the plan, there has been no interference with the Commission's decisions regarding premiums, plan design, cost-sharing, or provider reimbursement. The Commission regularly meets and has statutory responsibility for all aspects of health plan design. This is a five-member Commission made up of the Secretary of Administration, the Commissioner of Insurance, and three members serving at the pleasure of the Governor. These three members are one current state employee in classified service, a retired person from a position in classified service, and one member of the public who cannot be a state officer or employee.

The existing plan provides a price advantage to beneficiaries that fill prescriptions using a mail-order pharmacy. The mail order pharmacy is able to provide prescription drugs at a lower cost, because of the savings associated with their distribution and shipping costs. The proviso is expected to increase beneficiary and state costs for prescription drug benefits by diverting business away from low-cost mail-order refills to local pharmacies.

Current Plan Details

The State Employee Health Plan offers prescription drug coverage through a contracted Pharmacy Benefit Manager (PBM). The PBM maintains a network of local retail pharmacies and a mail-order pharmacy. Pharmacy reimbursement rates are contracted through the PBM and differ for retail and mail-order. Reimbursement rates are dependent upon a given drug's average wholesale price (AWP), and include a dispensing fee for retail prescriptions. Covered employees pay a coinsurance for prescriptions that is a percentage of the allowed amount. There are three tiers for employee coinsurance: 20 percent for generics, 35 percent for preferred brand name drugs, and 60 percent for non-preferred brand name drugs.

Currently the **retail** pharmacy reimbursement rate is:

AWP – 15% + $1.85 dispensing fee = Ex. $100 - $15.00 + $1.85 = $86.85
*The employee pays a percentage (20%, 35%, or 60%) of $86.85.

Currently the **mail-order** pharmacy reimbursement rate is:

AWP – 22.5% + no dispensing fee = Ex. $100 - $22.50 = $77.50
*The employee pays a percentage (20%, 35%, or 60%) of $77.50.

The proviso requires the Health Care Commission to equalize reimbursement rates for retail and mail-order pharmacy for plan year (calendar year) 2007. The current mail-order rate of AWP less 22.5 percent and no dispensing fee is below the average pharmacies' cost for prescription drugs, which is estimated to be AWP less 18 percent. Lowering the retail rate to the mail-order rate could disrupt the pharmacy network and result in reduced access for members. Therefore, the most likely consequence of this proviso is to increase the mail-

order reimbursement rate to the same level as retail; currently AWP less 15 percent plus a $1.85 dispensing fee. The proviso results in higher reimbursement to the state's PBM not community pharmacies.

6. PRESUMPTIVE MEDICAID DISABILITY:

The Budget Committee is concerned there is no process in place to address people who may not qualify for presumptive disability, but may ultimately qualify as disabled under SSA requirements. The Budget Committee recommends the Division of Health Policy and Finance (DHPF), the Health Policy Authority (HPA), and the Department of Social and Rehabilitation Services work together to address this issue and report to the Committee during Omnibus.

In order for a person to receive Social Security Administration (SSA) disability benefits, comprehensive medical evidence must be provided to validate that the person is incapable of "substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[1] If a person is denied benefits, they do have the right to appeal. Re-evaluations may also be considered if the person's condition worsens or they develop a new condition that warrants further assessment. While some people who have been denied benefits may ultimately qualify, it is the severity of their disability at a given point of time that is critical to the decision making process.

The scope of the MediKan program, as currently implemented, is designed to provide coverage from the point the federal disability claim is made and to serve as a bridge program during the application process. It is not designed to provide benefits for an indefinite period. If the person's disability does not meet the listing of impairments as defined by federal law, the person's claim is denied.

One of the purposes for establishing the presumptive Medicaid disability determination program is to help identify people with illnesses or conditions who are likely to meet the severity levels required by the SSA – the people MediKan was originally designed to serve. This new process will allow more immediate access to Medicaid benefits to those who qualify. Additionally, it will aid in the identification of alternative services that will provide increased treatment continuity for people who do not qualify. To help insure accuracy of the determinations, the presumptive Medicaid disability determination process will incorporate the same basic standards used by SSA. This includes obtaining and reviewing medical records to support the disability claim. In contrast, current General Assistance (GA)/MediKan beneficiaries are determined eligible when a physician, using a pre-printed checklist, indicates an impairment exists; medical evidence is not required currently to substantiate the disability.

DHPF and SRS staff have been involved in discussions centering on alternative services for people who are not presumed eligible for Medicaid via the presumptive Medicaid disability process for well over a year. Services that have been identified thus far include the availability of food stamps, making referrals to the local Community Mental Health Centers (CMHCs) for services and for aid through the community medication prescription program, linking the individual with the local workforce development center for employment services, providing referrals to vocational rehabilitation, and linking the individual with local helping agencies.

Only 25.0 percent of persons on MediKan ultimately qualify for SSA disability. Over 60.0 percent of persons currently on the MediKan program have a mental health diagnosis-resulting in mental health drugs being the largest cost driver for MediKan. Presumptive disability may shift people from MediKan

1 Social Security Disability Evaluation Under Social Security, January 2005.

services to the community mental health system, state hospitals, and jails. No additional funding provisions were made to address this possibility. The Budget Committee recommends the agency work with stakeholders to address this issue and report to the Committee during Omnibus.

Community Mental Health Centers (CMHCs) are required to ensure adequate mental health services are available to all inhabitants of Kansas, including adults with severe persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care (see K.S.A. 65-4433, K.S.A 39-1602, and K.S.A. 39-1603). People who do not qualify for Medicaid through the presumptive Medicaid disability determination process, but who have mental illness, should be able to access mental health services at CMHCs. The CMHCs are already prepared, and receive State Aid to serve this population along with any other Kansans in need of mental health services.

Additionally, only 33% of people who apply for GA/MediKan are approved presently. We have no evidence that the 67% who are denied are entering state institutions or jails. The CMHC system is designated and funded to serve all Kansans with mental illness, not just those for whom Medicaid or MediKan pays. The presumptive Medicaid disability determination process will give those who apply for GA a better opportunity to obtain Medicaid coverage and a better chance to meet SSA disability requirements, because of the work DHPF will do in collecting medical documentation of the disability.

Finally, the Legislature reduced the medical assistance budget based on anticipated MediKan savings from SRS last fiscal year for the implementation of the presumptive Medicaid disability determination process. However, given the complexity of program start-up it proved to be too difficult to implement in the timeframe available. DHPF is now trying to implement the process that was approved last legislative session.

The Governor's recommendation includes a savings of $7.0 million from the State General Fund for presumptive disability which may have to be restored if the presumptive disability criteria set by the state results in less than half of the persons presumed disabled qualifying for SSA disability.

As of this date, DHPF has not received any indication from CMS that a certain threshold of applicants must meet the State's presumptive Medicaid disability criteria to claim federal matching funds. Furthermore, there has been no suggestion from CMS that a specific error rate would prompt an audit or financial review of the program.

7. The Committee requests that SRS, Department on Aging, Division of Health Policy and Finance, Kansas Health Policy Authority, and the Department of Health and Environment report at Omnibus on the anticipated impacts on each agency from the Federal Deficit Reduction Act of 2005 enacted this year.

DEFICIT REDUCTION ACT:

The Deficit Reduction Act (DRA) includes notable changes in federal requirements for Medicaid programs and some new program flexibility for states. The DRA provisions either require mandatory changes in state Medicaid programs or add to the myriad of options already available to states in the administration of their programs. DHPF is in the process of evaluating many of the DRA provisions, with particular emphasis on the mandatory changes that have retroactive effective dates and those with effective dates before July 1, 2006.

DHPF is involved in discussions with partner agencies, including SRS and the Department on Aging, to review the impact of the DRA provisions and develop implementation strategies. Many of the provisions also require the Centers for Medicare and Medicaid Services to issue regulatory guidance. CMS has begun issuing guidance, in the form of State Medicaid Director letters and State Plan Amendment templates, on several of the provisions. We expect additional Medicaid Directors letters to be issued between now and July 1. CMS also is developing regulations to implement other provisions. DHPF is participating in state-to-state conference calls to discuss the impacts and clarify the intent of the CMS guidance.

The new flexibility included in the DRA, particularly on cost sharing, developing benchmarked benefit plans, and moving some Home and Community Based Services into the State Plan, would have significant impacts on the character of Kansas Medicaid. Understanding the impact of these options will take some time and will depend on how CMS interprets the provisions. DHPF is preparing a range of Medicaid reform options for presentation to the Kansas Health Policy Authority Board later this year, and these options will incorporate the new flexibility afforded by the DRA.

[Information Table Displayed on next page]

Provision	Description	Effective Date	Type (Mandatory, State Option, Demonstration Program)
Non-Emergency Medical Transportation Program	Allows states to contract with transportation brokers without obtaining a selective contracting waiver.	Upon enactment	State Option
Prohibition Against Covering Non-Adults with SCHIP Funds pregnant, Childless	Only states that have approved 1115 Waivers can use Title XXI money for single, childless adults.	Upon enactment	Mandatory
Enhancing Third Party Identification and Payment	It strikes the term "health maintenance organization" and substitutes it with "managed care organizations, pharmacy benefit managers, other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service." States must require parties legally responsible for payment of a claim to provide, upon request of the state, information to determine during what period an individual or their spouse and dependents may be covered by an insurer, and the nature of the coverage.	January 1, 2006	Mandatory
Targeted Case Management	Prohibits certain foster care activities from being claimed as medical targeted case management.	January 1, 2006	Mandatory
Prohibition on Restocking and Double Billing of Prescription Drugs	Pharmacies could not be paid to repackage drugs that were dispensed and returned to the pharmacy	The first day of the fiscal year quarter that beings after the date of enactment	Mandatory
Documentation Requirements	Requires proof of citizenship with specific types of documents that can be used for eligibility determination.	Applies to determinations of initial eligibility made on or after July 1, 2006	Mandatory
Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity	Increases the home equity limit from $500,000, and allows states to set the limit up to $750,000.	Applies to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006	Mandatory
Requirement to Impose Partial Months of Ineligibility	Eligibility penalty periods can be for partial months.	Applies to payments for calendar quarters beginning on or after the date of enactment*	Mandatory
Authority for States to Accumulate Multiple Transfers into One Penalty Period		Applies to payments for calendar quarters beginning on or after the date of enactment*	State Option
Inclusion of Transfer of Certain Notes and Loans Assets		Applies to payments for calendar quarters beginning on or after the date of enactment*	Mandatory
Inclusion of Transfers to Purchase Life Estates		Applies to payments for calendar quarters beginning on or after the date of enactment*	Mandatory
Disclosure and Treatment of Annuities	All applicants would have to declare interest in annuities and name the state as the remainder beneficiary.	Applies to transactions on or after the date of enactment	Mandatory
Application of Income-First Rule		Applies to transfers and allocations made on or after the date of enactment	Mandatory
Lengthening the Look Back Period from 3 to 5 Years		Applies to transfers made on or after the date of enactment	Mandatory
Change in Beginning Date for Period of Ineligibility		Applies to transfers made on or after the date of enactment	Mandatory

Provision	Description	Effective Date	Type (Mandatory, State Option, Demonstration Program)
Availability of Hardship Waivers		Applies to transfers made on or after the date of enactment	State Option
Premiums and Cost Sharing	Allows states to raise co-payments or premiums for Medicaid beneficiaries and would allow the co-payments to be enforceable as a condition of receiving the service	March 31, 2006	State Option
Federal Upper Payment Limit for Multiple Source Drugs	Statute creates a Federal Upper Limit (FUL) at 250% of average manufacturer price (AMP) for multisource drugs and creates a Retail Survey Price (RSP) for single source drugs. States currently use Average Wholesale Price (AWP) or Maximum Allowable Cost (MAC) pricing.	January 1, 2007	Mandatory
Collection and Submission of Utilization Data for Certain Physician Administered Drugs	Requires National Drug Code (NDC) to be provided on claims forms for drugs administered in physician offices and outpatient hospital services	January 1, 2007	Mandatory
Improved Regulation of Drugs Sold Under a New Drug Application (Generics)	Replaces "authorized generic" terminology with manufacturer drug sold under a new drug application (NDA) approved by the FDA. All NDA drugs would be included in best price requirements such as the FUL.	January 1, 2007	Mandatory
Expanded Access to Home and Community-based Services (HCBS) for the Elderly and Disabled	States may provide HCBS through state plan amendments. States could develop needs based criteria for determining eligibility for HCBS services for those 150% of the Federal poverty limit. Nursing facility level of care can be more stringent than that required for HCBS eligibility.	January 1, 2007	State Option
Cash and Counseling	Allows states to permit self direction of personal care services within a fixed individual budget.	January 1, 2007	State Option
Enactment of State False Claims Acts	States with false claims acts that meet criteria would be able to retain an additional 10% of recovered funds.	January 1, 2007	Mandatory
Employee Education About False Claims Recovery	The state must ensure that providers receiving at least $5.0 million in payments provide staff training and have written policies about the false claims act and preventing fraud.	January 1, 2007	Mandatory
Emergency Room Co-Pays for Non-Emergency Care	Hospitals could collect co-payment for emergency services when a non-emergent provider is available and the condition is not an emergency. Beneficiaries under 150% FPL or those exempt from copays would not be subject to emergency room copays.	January 1, 2007	State Option
Use of Benchmark Packages	States could provide services equivalent to a benchmark plan under Medicaid without regard to comparability, state wideness, or freedom of choice. This option would primarily be available to full benefit Medicaid eligibles in the TAF and poverty level eligible groups. Children under 19 would have to have access to all EPSDT services through the benchmark plan or a state wrap around.	January 1, 2007	State Option
Family Opportunity Act	Families with disabled children would be allowed to purchase Medicaid coverage. Children would have to be disabled based on SSI criteria and the families can not exceed 300% FPL.	January 1, 2007	State Option
Money Follows the Person	States selected for the demonstration of money following the person from institutional to community settings would receive enhanced federal Medicaid funding.	January 1, 2007	Demonstration Program
Health Opportunity Accounts	States could create Health Savings Accounts for Medicaid beneficiaries to incentivize preventative care and reduce inappropriate use of services. The state contributions to the accounts would be eligible for Medicaid matching funds	January 1, 2007	Demonstration Program
Emergency Services in Managed Care	Non contracted providers must accept the fee for service rate for emergency services provided to Medicaid beneficiaries enrolled in a managed care plan.	January 1, 2007	Mandatory
Additional Federal Payments Under Section 1115 Demonstrations		10 month FMAP adjustment	
Recalculation of Alaska's FMAP and Katrina FMAP calculation		Alaska – FY 2006 and 2007 FMAPS Katrina – 10 month FMAP adjustment	
Authority for Qualifying States to Use Certain Funds for Medicaid Expenditures	States can apply to use SCHIP funds to cover additional Title XIX eligible children.	Applies to expenditures made on or after October 1, 2005	State Option
Additional Funding Allotments for SCHIP	FY 2006 $283.0 million	Applies to items and services furnished on or after October 1, 2005 through October 1, 2006	

Provision	Description	Effective Date	Type (Mandatory, State Option, Demonstration Program)
Medicaid Integrity Program	Health and Human Services is appropriated $5 million in FFY 2006, and $50 million in FFY 2007 and 2008 to create a Medicaid Integrity Program. The additional funding would add 100 positions dedicated to detecting fraud and abuse and expand states participating in Medicaid and Medicare data matching	As state legislation is required in order to meet the requirements of the program, the state plan will not be regarded as failing to comply should these requirements not be met before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment. In the case of states with 2 year legislative sessions, each year of the session is considered to be a separate regular session of the state legislature	Mandatory
Transitional Medical Assistance Education Program and Abstinence	Transitional Medical Assistance continues Medicaid eligibility for individuals moving from cash assistance to work.	Extends TMA and appropriates funds for Abstinence Education through December 31, 2006	TMA – Mandatory Abstinence Education –State Option
State High Risk Health Insurance Pool Funding		Funds appropriated for FY 2006	
Increase in Payments to Insular Areas		Funds appropriated for FY 2006 and FY 2007	
Medicaid Transformation Grants	Provides $100 million in grants to states for innovations in effectiveness and efficiency by reducing patient error, enhanced estate recovery, and reducing fraud and abuse.	Funds appropriated for FY 2007 and FY 2008	State Option
Home and Community-based Alternatives to Psychiatric Residential Facilities for Children	Allows states to apply for demonstration authority to show cost effectiveness of providing community based treatment as an alternative to residential treatment.	Funds appropriated for FY 2007 through FY 2011	Demonstration Program
Family-to-Family Health Information Centers	Provides funding to 25 states to establish information centers to provide information to families of children with disabilities on choices of treatment.	Funds appropriated for FY2007 through FY 2011	State Option
Restoration of Medicaid Eligibility for Certain SSI Beneficiaries	Extends Medicaid eligibility to individuals under age 21 at the latter of the date of application for Social Security Income (SSI) or date of SSI eligibility.	One year after the date of enactment	Mandatory
Enforceability of Continuing Care Retirement Communities and Life Care Community Admission Contracts	Clarifies that Continuing Care Retirement Communities and Life Care Community Contracts are countable resources for Medicaid eligibility.		State Option
Expansion of State Long-Term Care Partnership Program	States can disregard assets or resources from Medicaid eligibility determination in an amount equal to the benefit payment of a long term care insurance product. The Insurance Department would certify that the long term care insurance policies meet minimum requirements. Regulations will be issued to develop required data elements that could be shared across states.		State Option
Managed Care Organization Provider Tax	Provider tax plans that assess managed care organizations (MCO) must uniformly tax all MCO's that operate in a state, whether they provide services to Medicaid beneficiaries or not.	Existing taxes are disallowed as of October 1, 2009, provided that the taxes were enacted in the state by December 8, 2005. Otherwise, effective upon enactment	Mandatory

8. The Budget Committee requests an update on dental claims processing.

Dental progress:

On July 1, 2006, all dental claims for Medicaid and State Children's Health Insurance Program (SCHIP) eligible beneficiaries will be processed by the Medicaid Management Information System (MMIS). This change was made to provide a single point of contact for dental providers and to simplify the claims payment and reconciliation process, which has been a source of concern for providers. Most of the complaints we hear from dental providers are about slow payment, unclear reasons for payment decisions, and low reimbursement rates.

Currently, all dental claims are sent to Doral Dental and then separated into claims for Medicaid beneficiaries and claims for SCHIP beneficiaries. The Medicaid claims are then sent to the MMIS system for processing. SCHIP claims are paid by Doral Dental as the managed care organization for all SCHIP. In the original system design, Doral Dental also served as an administrative services organization to provide clinical reviews, prior authorizations, and perform claims resolution and provider relations. While claims payment has improved, these contractual relationships have been difficult to manage and confusing to the providers.

To simplify the claims payment system for providers, EDS will pay all claims on a fee for service basis. The change will not affect the amount of reimbursement dental providers receive. This is the practice for Title XIX Medicaid claims, and is allowed for SCHIP by KSA 38-2001 (d) (8). At the same time, EDS will add provider representatives to work specifically with dental providers and claims representatives to work through billing and payment posting issues with dental practices. Payment policy changes have been implemented to simplify dental billing and to remove prior authorization paperwork for some procedures. The goal is to make the Medicaid payment methodologies consistent with the most current dental insurance practices. EDS is currently working with dental providers to start transitioning to the new billing system. EDS also is already working with some dental practices to demonstrate the internet billing system, and how to use the online system to verify eligibility and adjust claims.

Our plan is to make the claims payment process more transparent to dental providers. This change fully realizes the objective of having a single point of contact for dental providers for Medicaid and SCHIP. Our data shows that more dental providers are enrolled in Medicaid and that more dental services are being provided with each additional year. Expenditures for dental services through Medicaid have grown from $17.5 million in FY 2003 to $24.8 million in FY 2005. DHPF will continue to evaluate access to dental care and management tools available for dental services. At some point in the future, we may reintroduce capitated managed care to the SCHIP population and possibly expand into the traditional Medicaid population. We hope that focusing our attention on a single payer and emphasizing building relationships with providers will improve access to dental care.